Transparency	**Potential Recommendations:** • Support consumers' making informed choices by compiling and reporting existing price, quality and clinical outcome metrics on publicly-facing website(s) such as but not limited to ~~CIVHC's~~All Payer Claims Data Base (APCD). Ensure that the website(s) provides various tiers of timely information based on different consumers' understanding of price and quality data. ○ Create a state employee pilot using transparency tools to inform employees of the state of cost and quality metrics related to specific elective procedures. Have the results of the pilot published after two years to demonstrate usage, changes in behavior, and savings. This pilot would provide proof of concept for the commercial market. • Transparency is beneficial to more than just consumers. Research indicates that data provided to providers can change behavior. Thus, the state should seek to promote more transparent and publically available date with a focus primarily around facilities, pharmaceuticals and providers' prices using resources including but not limited to APCD. • Data that is made available for consumers and providers should be timely, accessible, consumer-friendly, actionable and regularly updated. • Encourage and support transparency vendors making data broadly available using the internet, including over mobile devices. • Encourage vendors providing transparency tools to incorporate data from multiple sources including the APCD to provide cost and quality data to clinicians and facilities at the point of service. Because quality metrics are emerging, continue to improve these metrics to support desire clinical outcomes. • Support a statewide total cost of care initiative (payments) to get an understanding of state costs relative to others states. • Explore the potential for financial incentives to motivate consumers to use decision aids. Pilot patient decision aids among Medicaid enrollees and state employees. Evaluate the pilot and disseminate results to inform the private sector. The pilot should focus on those diseases and/or procedures for which multiple treatment options exist.
	Parking Lots Items: • Disclosure and the publishing of fees/ taxes imposed on providers. • How to consider administrative cost in the statewide total cost of care initiative.
Workforce	**Potential Recommendations:** • Support and allow people to have meaningful access to primary care and speciality care service. Including but not limited to: ○ Encourage where possible statutory and regulatory changes to enable, health care professionals ~~being able~~ to practice at the top of their scope of practice.

	○ Work with CDPHE, community colleges and others to improve the supply and practice of nonprofessional individuals such as community health workers and other community members that can support efficient and cost effective community based delivery models. • Direct and support CDPHE to align state efforts, data sets, and assesses community needs to assess workforce needs on-going. • Request that the executive branch and legislature work in conjunction with the Commission on Family Medicine to make revisions to HRSA related to the federal Graduate Medical Education (GME) programs rules and regulations. ○ Seek additional slots in training programs in areas of CO workforce need. ○ Seek flexibility in GME requirements, especially in primary care, rural, and underserved training programs. • Investigate pathways to assist health care professionals seeking rapid entrance to the CO workforce and for those that are foreign trained. • Promote and support health care providers practicing in identified rural and underserved areas by increasing funding, eligibility, and policies including financial incentives (e.g., increase reimbursement, reduce debt load) for those willing to serve in these areas including but not limited to the National and Colorado Health Services Corps.
	Parking Lots Items:
Payment and Delivery Reform	**Recommendations:** • Support ongoing efforts (e.g., the work of the Multi-Payer Group, with the inclusion of the participation of providers and consumer groups) to develop common quality metrics across payers. Direct payers to use these to drive in order to drive value-based payment models and enhance public reporting of provider performance on quality and costs. Encourage experimentation with new forms of pricing and reimbursement including but not limited to: ○ Use of reference pricing for all payers ○ Warrantied payment for services~~, and~~ ○ Bundled Payments, including: • Adoption of bundled methodologies as appropriate for all payers including in the State's employees' purchase of certain procedures and conditions. ▪ Support a voluntary bundled payment program for: • State employees: Hips and knees, back surgery and congestive heart failure • Pre-Medicare state retirees: Continue for hip and knee replacements, pilot for back surgery and congestive heart failure • Medicaid: Chronic illness such as diabetes, asthma or heart failure ▪ Bundled payment programs will include: • Patient satisfaction measures

	• An evaluation of the effectiveness on cost and quality to inform the state and private sector and to augment the limited evidence that currently exists • Defined bundles that are consistent with other pilots (to the extent possible) ○ Consumer-directed care and payment approaches • Study the potential for equalizing payments in rural communities across all payers. • Create a pilot for state employees to adopt and test Value Based Insurance Design (VBID) approach to benefit design (e.g., high value services with low or no copay, lower value services with higher copays, etc.) in order to provide proof of concept for the marketplace. • Enhance primary care reimbursement using value-based models like the primary care medical home (PCMH) and integrated care models, and include adequate funding to fully implement these systems. • Enhanced per Member per Month (PMPM) payment in Medicaid through the RCCO's for high need, high cost complex patients, who have been identified as such through Statewide Data Analytics Contractor (SDAC) data, hospitals, healthcare organizations, community mental health centers. The PMPM would pay for the multidisciplinary team: a medical provider (NP/PA), behavioral health provider, care coordinator, health coach, dental/ oral health provider and a hospital based community health worker. The team would work intensely with the patient and link (or re-link) them into a medical home in the community once the patient completes the program. Should consider a shared PMPM for PCP and facility for care coordination. Metrics could then look at admission and ED visit rates. After program maturation there could be incentive metrics for performance to earn part of the PMPM. Core components for success include: ○ Close hospital partnerships for real time referrals and bedside enrollment ○ Behavioral health therapist as part of the team ○ Access to data: claims data, cost and utilization, and pre/post assessment for PH/BH capabilities within one EMR.
	Parking Lots Items: • Set a state target for increased system-wide spending on primary care • Encourage the Direct Primary Care model.
Market Competitiveness	**Recommendations:** •
	Parking Lots Items: •
Social Determinants	**Recommendations:** • Where appropriate reduce silos within state agencies so that Medicaid patients can receive the support needed to address their specific condition (e.g. housing, job training and/or placement) • Adoption of payment structures in Medicaid, such as braided or bundled funding, that address clients' social

	determinants of health ○ More meaningfully align state agencies on health and health care (health authority) ○ Pilot braided funding models for high utilizers for housing (MA showed savings) ○ Expand Medicaid ACC medical home model to braid in funding for social services, including supportive housing and employment • Continue to support investments in home visitation, including but not limited to programs like the Nurse Family Partnership • Create a pilot to identify urban, low-income patients with asthma from zip codes with high Emergency Department (ED) visits or hospitalizations due to asthma, and offer enhanced care including nurse case management and home visits. • Ask the legislature to provide financial support to measure the actuarial return on investment for public health
	Parking Lots Items: • CALPHO recommendations • Funding mechanisms for adverse childhood experiences / toxic stress
Regulatory Costs	**Recommendations:** •
	Parking Lots Items: •
Administrative Costs	**Recommendations:** •
	Parking Lots Items: •
Technology	**Recommendations:** •
	Parking Lots Items: •
Incentive Mechanisms	**Recommendations:** •
	Parking Lots Items: •
Other topics: Pharmaceuticals	• Recommend an ongoing, focused conversation between the legislature, executive branch, and Congressional delegation to promote active discussion and problem solving. These conversations should include the following topic areas: ○ Allow Medicare to negotiate prices

	○ Allow drug importation from other countries ○ Adjust the length of patents and criteria by which patents are renewed ○ Address the length of exclusivity ○ Evaluate rules and timeframes to bring a drug to market, including reducing the length of the FDA's evalution process • Study the feasibility of a reinsurance program for specialty drugs ○ Does not directly address price. But allows carriers and employers to spread risk. • Evaluate the feasibility of a multi state compact for the purchase of non specialty drugs
	Parking Lots Items: • Reduce patient cost sharing ○ Does not address price. Carriers would increase premiums to spread costs. • Require more transparency ○ Provides information needed in competitive markets, but barriers still remain for competition. • Implement price controls ○ Does Colorado have enough leverage? • Impact of 340B program